The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967

ABSTRACT

Explicit discrimination against minorities existed in the 1960s in hospital patient admissions and physician and nurse staff appointments. With passage of the Civil Rights Act of 1964, along with Medicare legislation in 1965, civil rights advocates within the federal government had both a legislative mandate to guarantee equal access to programs funded by the federal government in Title VI and a federal program that affected every hospital in the country in Medicare. This study was conducted to determine the extent to which the Medicare hospital certification program was a major determinant in the racial integration of hospitals throughout the United States. In-depth interviews were conducted with individuals involved in hospital and health care policy in the 1950s and 1960s. Other primary resources include archival and personal manuscripts, government documents, newspapers, and periodicals. (*Am J Public Health.* 1997;87:1850–1858)

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Introduction

Discrimination against African Americans still existed in the United States in every aspect of medicine in the early and mid-1960s.[1] African-American students were denied admission to most medical and nursing schools, African-American physicians were rejected from membership to state and national medical societies, and African Americans were refused care at most hospitals in this country. Social and political forces merged with passage of the Civil Rights Act of 1964. Title VI of the act forbade the distribution of federal government funds to programs and institutions that discriminated on the basis of race, creed, or national origin. One year later, President Lyndon B. Johnson signed the Medicare program into law. For the first time, civil rights advocates had both a legislative mandate to guarantee equal access to programs funded by the federal goverment in Title VI and a program that affected virtually every hospital in the country in Medicare.

This paper analyzes the steps taken by the federal government to eliminate explicit discrimination in access to hospital care for minorities and, in doing so, illustrates the use of health and program legislation to effect institutional and social change. Title VI of the 1964 Civil Rights Act was the landmark legislation essential to the federal government in its effort to achieve a new level of racial integration in American society. Furthermore, the Medicare certification program was essential in implementing a federal policy of equity in health care and thus was a critical tool in exposing and eliminating racism in medicine.

Hospitals and Federal Grant Programs

In 1959, Dr Paul Cornely, professor of preventive medicine at Howard University, investigated the extent of racial integration of medical schools, medical societies, BlueCross BlueShield plans, hospitals, and health agencies. To document the extent of hospital integration, he sent questionnaires to National Urban League chapters in 60 cities, 45 in the North and 15 in the South.

In the North, 83% of general hospitals reportedly offered patient care on an integrated basis. In the South, however, only 6% of the hospitals admitted African-American patients without restrictions. Of the remaining 94% of southern general hospitals, 33% did not admit any African-American patients, 50% had segregated wards, and the remainder had modifications of segregated patterns.[2] Cornely concluded that discrimination in access to hospital care and appointments to the medical staffs of hospitals was widespread throughout the United States.

Discrimination also existed in postgraduate residency training. In the North, only 10% of the total number of hospitals surveyed accepted African Americans as interns and residents, and only 20% had African-American physicians as members of the medical staff. In the South, only 6% of hospitals offered internships and resi-

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dencies, and 25% provided medical staff privileges to African-American physicians.[3] The larger percentage for staff privileges reflected the use of wards by African-American physicians in "mixed-race" hospitals. Cornely worked through the American Public Health Association to gain a wider audience for his message about discrimination. He sought to enlist public health officers and hospital administrators in the battle for equal access to hospitals for African Americans.

Dr W. Montague Cobb, professor of anatomy at Howard University and editor of the *Journal of the National Medical Association*, reviewed the landscape of racial integration and noted some change. By the late 1950s, 42% (11 of 26) of southern medical schools admitted African-American students. Of southern state medical societies (including the medical society of the District of Columbia) 53% (9 of 17) offered memberships to African-American physicians. With these changes, Cobb concluded that the time was ripe for an attack on "the greatest of all discriminatory evils, differential treatment toward African Americans with respect to hospital facilities."[4] A national agenda focused on hospital integration soon emerged, supported by the National Association for the Advancement of Colored People (NAACP), the National Medical Association, and the National Urban League.[5] The initial strategy was to eliminate the "separate but equal" clause of the Hospital Survey and Construction Act, commonly known as the Hill–Burton act.

The national strategy to eliminate racism in medicine focused on the collaborative efforts of Dr Louis T. Wright, chairman of surgery at Harlem Hospital and chairman of the board of directors of the NAACP; Cornely, of Howard University, an active member of the American Public Health Association and the National Urban League; and Cobb. Together, these physicians envisioned an annual Imhotep conference, which would bring together African-American physicians, congressional leaders, and journalists. Their goal was to develop a consensus that full integration and access to services in all-White hospitals and mixed-race hospitals was preferable to maintaining or expanding a separate hospital and medical care system for African-American professionals and patients. The first step along this path was to educate congressional leaders and the public—to show them that denial of hospital services to African Americans occurred throughout the country and had a negative impact on communities. Cobb and Cornely organized the Imhotep conferences so that African-American physicians would learn from other physicians, most often from northern cities, that access to better-equipped hospitals was preferable to maintaining a separate segregated hospital system. They intended ultimately to overturn federal legislation that sanctioned discrimination. When Congress passed the Hill–Burton act in 1946, it was heralded as a great step forward in civil rights because the legislation required that hospital facilities of equal quality be built for minorities and included a "separate but equal" clause to make specific this intention. During the first 17 years of the Hill–Burton program, approximately 70 separate health facilities (less than 1% of all Hill–Burton projects) were constructed either for White or for African-American patients. All other Hill–Burton projects were classified as "nondiscriminatory" facilities.[6] But as Cobb, Cornely, and Wright knew, and as participants at the Imhotep conferences learned, these "nondiscriminatory" hospitals routinely denied African Americans access to hospital services as patients and as members of the medical staff.[7] Consequently, the Hill–Burton program later became the target for change because "separate but equal" led to more inequality, especially when federal funds were used preferentially to build and expand hospital services for White Americans.

Communication between civil rights activists inside and outside the federal government increased under President John F. Kennedy. Cobb and other National Medical Association leaders met with Vice President Lyndon B. Johnson and outlined needed change.[8] Roy Wilkins, executive secretary of the NAACP, and Arnold Aronson, director of program and planning of the National Community Relations Advisory Council, conferred with President Kennedy and his staff on the needs of the administration in the area of civil rights. During the discussion, Kennedy's special counsel, Theodore Sorensen, requested more information on federal programs in which discrimination existed and ways it could be eliminated by executive action.[9]

Wilkins and Aronson convened the Leadership Conference on Civil Rights to address Sorensen's question. In the area of hospitals and federal grants, the conference report, *Federally Supported Discrimination*, noted that 10 southern states—Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, Tennessee, Texas, and West Virginia—required, by law, segregation in some of the hospitals or medical facilities that were eligible for and that received federal funds.[10] The Hill–Burton program specifically was targeted as the most important federal grant program in need of change. The Leadership Conference on Civil Rights recommended that the US Department of Health, Education, and Welfare (DHEW) reject "separate but equal" applications submitted under the Hill–Burton program.

Title VI of the 1964 Civil Rights Act: The Legislative Link to Hospital Integration

Congress, in the summer of 1963, debated a new civil rights bill. The title most relevant to DHEW was the proposed Title VI, which forbade the federal government to allocate funds to institutions and programs that discriminated on the basis of race, creed, or national origin. Secretary of Health, Education, and Welfare (HEW) Anthony Celebrezze testified that he endorsed passage of Title VI because he had ample evidence that there were hospitals, nursing homes, and outpatient clinics around the country that received federal funds while engaging in racial discrimination.[11] Celebrezze urged Congress to provide statutory means to end grants that supported discrimination and to do so in one broad stroke rather than by piecemeal amendment of program legislation to prevent inconsistencies and delay. DHEW had commenced a review of its programs to determine what authority already existed to limit funds paid to institutions that practiced discrimination. Celebrezze admitted he had taken steps to terminate federal funds to such institutions when possible under the limits of the law.

Adding to the political pressure, the United States Commission on Civil Rights published its annual report addressing discrimination in hospitals receiving federal funds in the fall of 1963.[12] This bipartisan commission was established by the 1957 Civil Rights Act to provide the federal government and Congress with accurate information on civil rights issues. In preparing the report, the commission staff conducted public hearings and field studies, reviewed reports of state civil rights advisory boards, and conducted a mail survey of hospitals.

Questionnaires went to 389 hospitals in 34 states: 45 in border states, 130 in southern states, and 214 in northern and western states. Fifty-five percent of hospitals responded. Of the 64 hospitals that responded from southern states, 85% practiced some form of segregation. More significant, nearly 100% (59 of 60) of hospitals with discriminatory policies were licensed by a political authority such as a

city, county, or state agency. In addition, 60% of these hospitals had received Hill–Burton construction grant funds. The Commission on Civil Rights proved again that discrimination occurred in federally funded hospitals. The commission called for an end to the use of federal dollars to expand segregated hospitals and called for Congress to enact appropriate legislation.

The Civil Rights Act was passed in the summer of 1964. Title VI of the act contained three essential elements: (1) it established a national priority against discrimination in the use of federal funds; (2) it authorized federal agencies to establish standards of nondiscrimination; and (3) it provided for enforcement by withholding funds or "by any other means authorized by law." It immediately conditioned $18 billion, or 15% of state and local revenues, on nondiscrimination and mandated that 22 federal agencies and departments no longer distribute federal funds to institutions that practiced discrimination in any form.[13]

Enforcement of Title VI was specified in the legislation and subsequent regulations. If effective, Title VI would convince the recipient agency or institution that it would benefit more by complying with federal regulations than by losing the funds. Actual withholding or terminating of funds meant that Title VI had failed. DHEW's Title VI regulations, approved by President Lyndon B. Johnson in December 1965, became the template for other federal agencies.[14] Shortly thereafter, the Commission on Civil Rights hosted a daylong conference, "Equal Opportunity in Federally Assisted Programs," to educate government officials on the significance of Title VI as it related directly to various federal programs. More than 400 government and voluntary organization leaders attended.[15]

During the session on health and welfare, Dr Luther Terry, surgeon general of the US Public Health Service, calculated that 5000 health institutions received public health service funds and had to comply with Title VI. Terry believed that voluntary compliance with the law was preferable to punitive action.[16] He published his views on the racial integration of health institutions in *Hospitals*, the journal of the American Hospital Association, 1 month after the Commission on Civil Rights' conference on Title VI and federal programs. Several months later, *Hospitals* carried another article describing how Titles II, III, and VI of the 1964 Civil Rights Act affected hospitals. The writer discerned the relevance of Title VI and included the text of its regulations, as well as cautioning that, in the future, Title VI would affect all hospitals certified for Medicare if the legislation passed.[17]

Specifically, Title VI provided that "no person in the United States shall, on the ground of race, color or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal assistance." Title VI, as applied to all hospitals receiving federal funds, stipulated the following:

- Patients must be admitted to facilities without regard to their race, creed, color, or national origin.
- Once admitted, patients must have access to all portions of the facility and to all services without discrimination. They may not be segregated within any portion of the facility, provided a different service, restricted in their enjoyment of any privilege, or treated differently because of their race, creed, color, or national origin.
- Professionally qualified persons may not be denied the privilege of practice in the facility on account of race, creed, color, or national origin.
- Residents, interns, nurses, and medical technicians may not be denied training opportunities in the facility on account of their race, creed, color, or national origin.
- No institution receiving federal funds may, directly or indirectly, use criteria or methods of administration that would defeat or impair the accomplishment of the program objectives for individuals of a particular race, creed, color, or national origin.[18]

Trial by Fire: Designing a Hospital Civil Rights Compliance Protocol

James Quigley, assistant secretary of HEW, had oversight for all of the departmental civil rights activities. In that capacity, in the early and mid-1960s he traveled throughout the South speaking to local boards of education as part of his strategy to integrate public schools. In doing so, he learned several lessons. First, a southerner, preferably someone with prestige and a government title, should accompany the staff person from Washington. Second, many people wanted to abide by the law and comply with the federal government's new guidelines for school integration but needed to blame such a change on a group outside their local community. Third, consistency in the message of integration and determination to enforce federal guidelines was crucial in establishing trust and ensuring that racial integration became a permanent change.[19]

In the area of health care, Quigley faced an enormous task. The federal government had never reviewed hospitals for civil rights compliance, except occasionally a Veterans Administration hospital. Acting on his experience in the South with school boards, Quigley developed a strategy to use southern public health service officers to evaluate the Title VI complaints regarding hospital civil rights noncompliance.[20] He hired Sherry Arnstein to direct DHEW's hospital civil rights compliance program, in part because of her previous experience in racially integrating the general hospital in Alexandria, Va. Together, Quigley and Arnstein constructed a mechanism to review the numerous complaints regarding hospital noncompliance with Title VI occurring principally in the southern states. With a team of eight Public Health Service officers from the Atlanta regional office, Arnstein traveled into southern communities to meet with hospital administrators, physicians, and trustees to discuss the Title VI guidelines as they related to noncompliant hospitals.[21] At these meetings, Arnstein and her team often faced resistant and angry administrators, trustees, and physicians; however, they pushed forward.

Arnstein learned that hospital administrators would integrate their institutions if money was involved. She and Quigley established a protocol such that no new Public Health Service or other federal grant funds would be approved and previously committed funds would not be released until a hospital met civil rights compliance standards. At the large teaching hospitals, each day of noncompliance meant substantial lost income.[22]

In an update on the department's Title VI activities, Celebrezze wrote that in the area of hospitals, Arnstein's team had integrated 21 hospitals in nine southern states.[23] While successful, Arnstein knew that without new program money, it would be impossible to guarantee compliance among 7000 hospitals in the United States. Recently signed into law, Medicare, an insurance program for the elderly that would affect virtually every hospital through a certification process and payments to hospitals for medical services to elderly patients, provided an opportunity to integrate hospitals on a massive scale. Arnstein recognized this immediately, yet realized that the leadership of DHEW regarded Medicare primarily, if not solely, as a health insurance program for the elderly, not as a tool for achieving the racial integration of hospitals.[24]

In September 1965, 3 months after President Johnson signed Medicare into law, Assistant Secretary Quigley told a

packed audience at the American Hospital Association meeting:

> In passing the [Civil Rights Act], Congress made it clear that federally assisted programs everywhere in the Nation must cease and desist from all forms of discrimination. . . . Restricting the staff privileges of [African-American] physicians to treating [African-American] patients; avoiding the promotion of [African-American] nurses to positions in which they would supervise white nurses, assigning rooms on the basis of racial rather than medical considerations—these and other practices, which are. . .widespread in all parts of the country, constitute discrimination just as separate entrances and wards and the denial of services constitute segregation.[25]

Quigley outlined what civil rights compliance meant for hospitals. Furthermore, according to Quigley, "not listed in the [Title VI] regulations—because it did not exist at the time—is health insurance for the aged, which is popularly known as Medicare. But to be eligible for next year's Medicare funds, hospitals would definitely have to comply with the 1964 Civil Rights Act."[26] Medicare would go into effect on July 1, 1966, in less than 10 months.

Making Hospital Civil Rights Compliance a Top Priority

President Johnson, in creating his new cabinet, asked John Gardner to serve as secretary of HEW. Gardner recognized the tremendous contribution of Quigley in developing the department's strategy for civil rights. On Quigley's advice, Gardner created the Office on Civil Rights and hired Peter Libassi as special assistant to the secretary on civil rights.[27] Libassi had formerly directed the Commission on Civil Rights' Title VI and federal program activities. He was the expert in Washington on Title VI and its application to federal programs. When Libassi first met with Gardner, he was impressed by Gardner's sincerity and commitment to civil rights. Libassi, however, listed 10 conditions that must be met prior to his acceptance of Gardner's job offer, one being Gardner's willingness to terminate all federal funds to any institution that was found to be noncompliant with civil rights guidelines. Gardner, in response, agreed to all 10 conditions and told Libassi that, in his opinion, nothing was more important to the nation during this decade (if not the century) than the racial integration of all of America's institutions.[28]

Shortly after joining DHEW in January 1966, Libassi sent to Lee White and Douglass Cater of the White House executive staff a plan for Title VI implementation among hospitals as part of the Medicare program. The Public Health Service was developing a special compliance packet that included a letter from the surgeon general and a questionnaire. On the basis of the questionnaire, compliant hospitals would be certified and noncompliant ones investigated by field review teams. Nationally, Libassi estimated that 80% of hospitals were in compliance or would make immediate changes necessary to meet federal guidelines. Field visits with a small staff would bring another 10% of hospitals into compliance, leaving only a small percentage of the nation's 7000 hospitals outside Medicare by the fall.[29] Libassi asked Arnstein to remain as head of the policy section for hospitals and to work with Robert Nash of the Public Health Service in implementing their policies and plans.

Libassi, in retrospect, credits Arnstein with the most important policy decision in hospital integration. She determined that hospitals must be required to comply immediately with federal racial integration guidelines in order to be accredited to participate in Medicare and that they would not be permitted to submit "go slow" plans as had been the protocol for public schools.[30] Libassi accepted Arnstein's policy recommendation; however, he did not anticipate the degree of resistance he would meet or the extent of racism that existed in hospital care.

Compliance, as specified in Title VI, meant that minority patients would have access to all services in a hospital, that minority physicians would be granted hospital privileges, and that employment opportunities would be available without regard to race, creed, color, or national origin. Arnstein recognized that the most sensitive indicator of hospital compliance was the placement of both African-American and White patients in the same patient-care room. Crucial steps included closing separate snack bars and cafeterias for African-American employees, eliminating bathroom signs that marked facilities "Colored" and "White" for employees and patients, and documenting that medical services within an institution were being used by all patients equitably.

Public pressure mounted in the attack against discrimination in medicine with front-page stories in the *Wall Street Journal* and extensive articles in lay and professional journals challenging DHEW to decide whether or not it would strictly adhere to its civil rights guidelines for Medicare certification of hospitals.[31] John Gardner, in reflecting back, remembered a time when hospital civil rights compliance was not an integral part of the thinking of individuals responsible for Medicare implementation. DHEW was engrossed in school desegregation; hospitals had not become a focus of the department's civil rights energy. However, in February 1966, Gardner called together Peter Libassi; Philip Lee, assistant secretary of HEW; Robert M. Ball, secretary of the Social Security Administration; and William Stewart, surgeon general of the Public Health Service. With raised voice, Gardner demanded that hospital desegregation become a top priority for all concerned. No hospital would be certified for Medicare unless it complied with Title VI, and whatever was needed in terms of staff, office space, telephones, and funds would be made available.[32]

In March 1966, Robert Nash, working under the direction of William Stewart, opened the Office of Equal Health Opportunity, using an entire floor of the Social Security Building equipped with phones provided by Secretary Robert M. Ball. Nash hired 100 employees to staff the office and 300 people as Medicare certification officers. These individuals went into the field to inspect hospitals.[33] Nash was charged with the responsibility of guaranteeing that those hospitals certified to participate in the Medicare program met civil rights guidelines in terms of patient admissions and professional staff appointments as specified under Title VI of the 1964 Civil Rights Act. In launching the Medicare hospital certification initiative, DHEW sent to all 7000 hospitals a civil rights compliance packet. The Office of Equal Health Opportunity sent a second mailing in mid-April.[34]

Preliminary data on hospital compliance available by April 1966, 3 months before the start of Medicare, signified an impending disaster. Only 49% of hospitals and 42% of hospital beds in the country met Title VI compliance standards. Region IV, which encompassed the southern states, had the lowest rates of compliance: 25% of the total number of hospitals and only 11% of the total number of hospital beds. Seven southern states had 15% or less of hospitals in compliance.[35]

The crisis Gardner and the DHEW team faced was both medical and political. President Johnson had risen through the Senate representing the southern state of Texas. He signed the Medicare legislation in Missouri with former President Harry Truman. Medicare was the centerpiece of Johnson's Great Society and the first major health program since Hill–Burton in 1946. Furthermore, at the height of the civil rights

TABLE 1—Crucial States in the Title VI Hospital Compliance Program, 1966

	Hospitals Referred for Medicare, %	Hospitals Not Replying to Packet, %	Hospitals with Discriminatory Practices, %
National average	60	20	18
Alabama	21	29	50
Arkansas	41	24	33
Florida	26	27	47
Georgia	16	36	41
Kentucky	48	17	35
Louisiana	10	44	46
Mississippi	3	56	41
North Carolina	27	15	34
South Carolina	10	32	36
Tennessee	44	27	29
Texas	40	32	28
Virginia	11	46	32

Source. Data were derived from Marvin Watson, "Memorandum, June 29, 1966," HU2 executive file, Lyndon Baines Johnson Presidential Library.

movement, President Johnson could not easily compromise his stand on racial equality, yet he wanted this national program to succeed. Gardner, as secretary of HEW, needed to ensure access to hospitals for elderly Americans who now would benefit medically from provision of services under Medicare that previously had gone uncompensated. What would happen if hospitals simply refused to comply with racial integration guidelines? Many feared complete loss of support to DHEW and the White House if civil rights guidelines were enforced strictly under the Medicare accreditation program. Ultimately, Congress could slash DHEW's budget and the public withdraw its vote for the Johnson presidency. Gardner took the risk and plunged in with his leadership team.

The Office of Equal Health Opportunity under Robert Nash set out to increase hospital compliance with Title VI principally in the states labeled "crucial": those of the South (Table 1). The 300 detailees (mostly from the Public Health Service and the Social Security Administration) hired to conduct field inspections beginning in the spring of 1966 underwent an intensive training program to learn how to detect evidence of racial discrimination in hospitals they were to certify for Medicare and how to communicate a consistent message to hospital administrators, trustees, and physicians.[36]

As a result of these field inspections, several patterns emerged. First, there were hospitals that believed they were desegregated and in compliance but in fact were grossly noncompliant. This situation required education on Title VI regulations specifically as they applied to the hospital in question. A report was written and the hospital visited again to ensure that changes had been made prior to certification for Medicare funding. The least common situation was the recalcitrant hospital that simply refused to comply and thus refused to participate in Medicare. The most common scenario was one in which the hospital had already made the necessary changes prior to the site visit. Less common but still frequent were situations in which the hospital administrator would pull the field officer into a room, shut the door, and say, "I'm glad you're here because I've wanted to desegregate but my board of managers won't let me. Now I can do what is right and blame it on the federal government. Thanks." Segregation was costly and inefficient and contributed to duplication of linens, blood banks, cafeterias, and waiting rooms. Field officers recognized that the financial incentive of Medicare dramatically sped up the rate of social change in hospital admission policies.[37]

By mid-May, however, progress toward hospital compliance still was so slow that the DHEW feared that widespread areas of the South might be left without a single hospital eligible for Medicare on the first of July. Leo Gehrig, deputy surgeon general, talked to Dr Edwin Crosby, president of the American Hospital Association. Crosby offered to provide Gehrig any assistance he could. As Gehrig remembered, Crosby stood out among the leadership of medicine because of his willingness to help integrate hospitals. The Public Health Service and the American Hospital Association arranged for 20 hospital association executives and presidents to meet with Gehrig in Washington. The American Hospital Association prepared a 15-minute film and a pamphlet on hospital integration and distributed 60 copies to state hospital associations throughout the South. The film was shown at local, state, and national meetings for the next several months.[38] Doors that only Crosby could unlock opened for Gehrig.

On June 18, Peter Libassi sent the White House staff a memorandum outlining DHEW's progress in hospital certification for Medicare. The staff distilled the information and sent it on to President Johnson. As Libassi emphasized, Vice President Hubert Humphrey lent his support by contacting a list of mayors provided by DHEW in key cities in Louisiana, North Carolina, Tennessee, Florida, and Texas. Humphrey planned to call mayors in Alabama and send them a report detailing the compliance status of hospitals in their cities.[39]

Libassi initiated meetings with state delegations and congressional staff in Washington. There was much resistance to gathering all of the senators, representatives, and their staff as a state delegation to discuss hospital compliance within their districts and states. Consequently, Libassi and his staff spoke individually with congressional staff and elected officials. By mid-June, they had met with people from Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.[40]

Libassi and his staff provided senators and representatives with information on hospital compliance in their jurisdictions as well as names of people at the local level. They discussed strategies to get hospitals certified. Libassi intended to apply pressure from the top down and to inform select senators and representatives that their citizens would be denied hospital and medical care as a result of a hospital's refusal to comply with federal law while at the same time attacking hospitals locally through repeat site visits and official compliance reports.[41] In addition, Secretary Gardner

TABLE 2—Hospital Beds Available for Medicare, 1966

	June 3, %	June 18, %	June 29, %
Alabama	15	24	36
Arkansas	42	85	91
Florida	55	86	93
Georgia	32	69	87
Kentucky	70	90	92
Louisiana	41	54	60
Mississippi	6	11	31
North Carolina	42	82	93
South Carolina	18	54	62
Tennessee	40	68	79
Texas	72	90	95
Virginia	29	42	47

Source. Data were derived from Cater.[29]

scheduled a meeting with the Senate and House caucuses to brief them on the Medicare program generally. Meetings also were planned with delegations from Alabama, Georgia, North and South Carolina, and Virginia.[42]

The meeting with the Louisiana delegation had a surprising twist. Senator Long expressed the view that while the people of Louisiana did not favor the Civil Rights Act, they would abide by its requirements. Furthermore, Congressmen Edwards and Willis said they thought there was no point in trying to persuade DHEW to change its policies nor in making speeches about "states' rights." Hospitals wanting federal funds would simply have to comply. The word was out. DHEW would not cave in.[43]

Applying pressure from various sides, federal government leadership continued its strategy of publishing articles in medical journals, meeting with leaders in medicine, and traveling extensively throughout the South educating hospital administrators on federal policy. As of June 14, five southern states still had less than 40% of their hospitals in compliance with Title VI regulations.[44] The following day, the White House hosted a conference that drew more than 200 physicians and hospital administrators. In his address, President Johnson highlighted the long hours spent testifying on behalf of Medicare, the campaign to achieve 90% enrollment levels, the more than 200 meetings between DHEW leadership and members of the health profession, and the fact that the federal government had sent hundreds of workers throughout the country into the field to consult and exchange views with hospital authorities. Johnson noted, however, that problems persisted. It was the responsibility of all of the people present to solve these problems, one being hospital compliance with Title VI. Johnson stressed that every citizen must obey the law.[45]

The tide was turning. As of June 18, 85% of hospitals and 87% of hospital beds in the country were in compliance with Title VI and available for Medicare recipients. Crosby of the American Hospital Association continued to arrange meetings between the federal government leadership and local hospital administrators and to distribute literature on Title VI compliance standards to noncompliant hospitals. Surgeon General William Stewart remembered that he saw Gehrig, his deputy, more often in airports traveling throughout the South than in Washington. Adding pressure, BlueCross officials told administrators of noncompliant hospitals that after July 1, persons more than 65 years of age would not be covered by BlueCross BlueShield because they would be eligible for Medicare.[46]

As part of the multidimensional strategy, DHEW established information units in the national Public Health Service headquarters and in regional offices devoted full-time to Medicare and Title VI. Through an extensive arrangement with the *Atlanta Constitution*, senior information officers visited key newspaper editors in Florida, Georgia, and Tennessee. The unit contacted national and local press agents of newspapers, radio and television stations, and professional organizations. The staffs in Charlottesville, Atlanta, and Dallas issued information on a regional basis and contacted local newspaper editors, scheduled television spots, and arranged advance press coverage for DHEW officials visiting their regions.[47]

No one knew whether or not DHEW would achieve success and be able to guarantee both elderly and minority Americans access to hospitals throughout the country when Medicare began on July 1. Under crisis conditions, Assistant Secretary Philip Lee and Deputy Assistant Secretary George Silver developed an emergency mobile medical plan whereby federal medical facilities would temporarily be opened to the public. Some of these hospital beds existed under the Veterans Administration system, some were located in hospitals on military bases, and others were to be opened in makeshift housing quarters staffed with Army medical personnel. The plan, elaborate in design, would be activated if all other avenues remained closed.[48]

On the eve of launching Medicare, Libassi prepared the statistics for hospital compliance. The White House staff sent President Johnson a memorandum describing hospital compliance with racial integration guidelines. Fourteen states and three territories had 100% compliance. Of the southern states, all but five had more than 80% of their hospital beds available for Medicare recipients (Table 2). Later that night, President Johnson took to the air and addressed the American people:

> Tomorrow, for the first time, nearly every older American will receive hospital care—not as an act of charity, but as the insured right of a senior citizen. Since I signed the historic act last summer, we have made more extensive preparation to launch this program than for any other peaceful undertaking in our nation's history. Now we need your help to make Medicare succeed. Medicare will succeed—if hospitals accept their responsibility under the law not to discriminate against any patient because of race. . . . Medicare will succeed—if doctors treat their patients with fairness and compassion as they have in the past. . . . Medicare will succeed—if older patients cooperate. . .and do not demand unnecessary hospital and medical services. . . . This program is not just a blessing for older Americans. It is a test of our willingness to work together. In the past we have always passed the test. I have no doubt about the future. I believe that July 1, 1966, marks a new day of freedom for our people.[49]

Securing Compliance through Executive Implementation and Judicial Review

Gardner was pleased to announce to President Johnson on July 5 that the Medicare story made headlines on front pages coast to coast and that, uniformly, the response was favorable. No crisis occurred; there were no calls to the national Information and Referral Center. Hospital compliance continued; the Office of Equal Health Opportunity even approved hospitals over the holiday.[50] The emergency plan for mobile medical units stayed as a backup plan on file.

Title VI civil rights compliance for hospitals now entered its third phase. All hospi-

tals that failed to submit DHEW Title VI compliance forms and refused to comply voluntarily were sent a letter advising them that unless they complied with federal regulations, they would be sent a notice of opportunity for hearing to determine whether their Medicare application would be denied and whether their eligibility for federal funds under all other federal programs would be terminated. State agencies would be notified of the hospital's status, which could result in termination of state welfare contracts. Congressional representatives and senators would be notified before letters concerning hearings were sent to hospitals in their districts. Finally, the White House would be informed of all actions by Libassi's staff concerning potential withdrawal of federal funds.

By early October, at least 43 hospitals in 10 states learned that they were not in compliance with Title VI civil rights standards and that, if their practices persisted, they could become ineligible for all federal funds. One hospital was located in New York and the remainder in the South. Several hospitals used receipt of the letter as an opportunity to comply, but most stood adamant in maintaining discriminatory practices.[51]

Nash reviewed the progress and success of the Medicare initiative at the American Public Health Association's annual meeting in early November. More than 7160 hospitals had been certified to participate in Medicare, while 35 had received a notice of opportunity for a hearing. The Office of Equal Health Opportunity was still working with 100 hospitals to bring them into compliance, and 215 hospitals had decided not to accept federal funds. Nash's staff visited almost 3000 hospitals and found that more than 2000 had changed their discriminatory practices before the team arrived.[52]

While Nash and the DHEW leadership team felt great accomplishment in their efforts to certify hospitals for Medicare, Wilbur Cohen, undersecretary of HEW, admitted that compromises in racial integration requirements were made in some parts of the South,[53] including Atlanta. Physicians practicing in Atlanta's private hospitals simply refused to admit African-American physicians to their medical staffs and, at the same time, continued to admit their African-American patients to Grady Memorial Hospital. DHEW could not afford politically to deny hospital services to elderly Americans in Atlanta; however, civil rights activists in the federal government would not rest until the problem of double standards was admitted explicitly and a thorough study conducted.[54]

By the end of February 1967, all outstanding cases of hospital civil rights compliance had been reviewed. Each medical facility receiving a letter of deferral had been cleared, approved for a notice of opportunity for hearing, or otherwise appropriately processed. Those hospitals that had been approved after long negotiations would be reviewed again soon to ensure their continued adherence to Title VI requirements.[55]

In the spring of 1967, Secretary John Gardner reviewed the cases of six hospitals that had failed to meet Title VI requirements and that did not respond to notices of opportunity for a hearing.[56] Libassi sent Gardner a list of 10 more hospitals in May.[57] According to Libassi, every hospital case he sent to Gardner for final review was deemed ineligible for all federal assistance. Gardner and Libassi stood firm in their commitment that the federal government would explicitly use Title VI and Medicare to transform hospital and health care in this country and, in doing so, achieve a new level of equality and access.

Conclusion

The merging of social, political, legal, medical, and professional forces in the 1960s culminated in a major transformation in hospitals in the United States. Through a series of court battles that led to victory in *George C. Simkins and A. W. Blount, Jr, et al. v Moses H. Cone Memorial Hospital*, civil rights advocates achieved one essential component necessary to lay a foundation for the racial integration of health care.[58] The next critical step was securing legislative language that would apply to all federal programs, not just the Hospital Survey and Construction Act (Hill–Burton). This was accomplished through Title VI of the 1964 Civil Rights Act, which stipulated that all federal funds must support only those programs and institutions that provide services to all Americans regardless of race, creed, or national origin.

One year after President Johnson signed the 1964 Civil Rights Act into law, he secured passage of Medicare, which would provide financial support to hospitals for medical care to elderly patients, a cost that previously had gone uncompensated. With one stroke, more than 7000 hospitals were subject to civil rights regulations set forth in Title VI of the Civil Rights Act. The test would be put to the executive branch of the federal government in terms of implementation. The judicial branch defended the concept of liberty and access to health care in *Simkins*. The legislative branch extended the civil rights of Americans in the 1964 Civil Rights Act. Now the executive branch needed to secure compliance with civil rights in every hospital eligible for Medicare in less than 1 year from passage of the legislation to full implementation of the program.

The Medicare hospital civil rights certification program was a massive undertaking that consumed the energy of the leadership staffs of DHEW and the Public Health Service for nearly a year. The team of leaders began with James Quigley and Sherry Arnstein, who developed the protocol for field inspections and set the policy of civil rights compliance prior to renewal or approval of any federal funds. Peter Libassi joined the group under the direction of John Gardner and Philip Lee, who worked hand in hand with Robert M. Ball, William Stewart, and Wilbur Cohen. Their deputies included George Silver, Leo Gehrig, and Robert Nash. Twenty years later, these individuals recalled the hospital civil rights compliance initiative under Medicare as one of the most meaningful and powerful experiences of their lives, one that brought them together through common values, commitment, hard work, and a dream of improved access to health care for Americans.

Beyond the effort to hire and train 300 officers to conduct hospital inspections, the Public Health Service sent mailings to hospitals, organized meetings between DHEW leaders and hospital presidents and boards of trustees, and published articles in major medical and hospital journals to get the word out that the federal government was determined to apply civil rights standards to hospital care. DHEW collaborated closely with the American Hospital Association in getting the message to hospital administrators and, along with the Office of Equal Health Opportunity, Vice President Hubert Humphrey, and the White House executive staff, applied pressure to local communities through state senators and congressional representatives. It also orchestrated an elaborate plan to use television and newspapers to publicize the move toward hospital compliance as it happened. Fortunately, the multidimensional approach proved successful such that, on the eve of launching Medicare, President Lyndon Baines Johnson addressed the American public, guaranteeing them that they would for the first time experience a new level of freedom and access to health care in this country.

In the following months, Libassi formalized the review procedure for hospitals found to be noncompliant with Title VI

guidelines through analysis of the situation by his staff; communication with the White House executive staff, congressional representatives, and senators; and, ultimately, referral to the Justice Department. After completion of a detailed assessment, all of those hospitals whose names Libassi forwarded to John Gardner were declared ineligible for federal funds.

In conclusion, Medicare has been viewed by most observers and scholars primarily as a mechanism to pay for health care for the elderly. However, as former HEW Secretary Wilbur Cohen, a principal architect of the Medicare legislation, wrote in 1977,

> There is one other important contribution of Medicare and Medicaid which has not yet received public notice—the virtual dismantling of segregation of hospitals, physicians offices, nursing homes, and clinics as of July 1, 1966. . . . If Medicare and Medicaid had not made another single contribution, this result would be sufficient to enshrine it as one of the most significant social reforms of the decade [if not the century].[59] □

Endnotes

1. P. P. Reynolds, "Hospitals and Civil Rights, 1945–1963: The Case of *Simkins v. Moses H. Cone Memorial Hospital*," *Annals of Internal Medicine* 126 (1997): 898–906.
2. P. B. Cornely, "Trends in Racial Integration in Hospitals in the United States," *Journal of the National Medical Association* 49 (1957):8–10.
3. Ibid.; P. B. Cornely, "Segregation and Discrimination in Medical Care in the United States," *American Journal of Public Health* 46 (1956): 1074–1081.
4. W.M. Cobb, "NAACP's Resolutions on Health," *Journal of the National Medical Association* 45 (1953):438–439.
5. P. P. Reynolds, "Hospitals and Civil Rights."
6. United States Commission on Civil Rights, *Equal Opportunity in Hospitals and Health Facilities: Civil Rights Policies Under the Hill–Burton Program*, CCR Special Publication no. 2 (Washington, D.C.: U.S. Government Printing Office, 1965).
7. A. L. Riday and W. J. Lear, *Health Care and the Negro Population* (New York: National Urban League, 1965).
8. "N.M.A. Delegation Meets with Vice President on Hospital Bias," *Journal of the National Medical Association* 55 (1963): 258–260; John F. Kennedy to Dr. Montague Cobb, "Greetings to Imhotep from the Honorable John F. Kennedy, President of the United States," *Journal of the National Medical Association* 54 (1962): 500–501.
9. Leadership Conference on Civil Rights, *Federally Supported Discrimination* (New York: Futuro Press, 1961), 7.
10. Ibid.
11. Statement of Anthony J. Celebrezze, accompanied by James M. Quigley, Francis Keppel, and Dean Corton, *House of Representatives Hearings on Miscellaneous Proposals Regarding the Civil Rights of Persons Within the Jurisdiction of the United States before Subcommittee No. 5 of the Committee of the Judiciary*, 88th Congr., 1st sess., 1963, 1507–1571.
12. United States Commission on Civil Rights, *Civil Rights '63: 1963 Report of the United States Commission on Civil Rights* (Washington, D.C.: U.S. Government Printing Office, 1964).
13. "Comment—Title VI of the Civil Rights Act of 1964—Implementation and Impact," *George Washington Law Review* 36 (1968):824–1022.
14. Ibid.
15. "Remarks by Luther J. Terry," *Journal of the National Medical Association* 57 (1965): 164–165; United States Commission on Civil Rights, *Equal Opportunity*.
16. L. J. Terry, "How Civil Rights Regulations Affect Hospitals," *Hospitals* 39 (1965): 139–146.
17. "Hospitals and Title VI of the Civil Rights Act." *Hospitals* 39 (1965): 34–37.
18. United States Commission on Civil Rights, *Equal Opportunity*, 3, 8.
19. Interview with James M. Quigley, 3 March 1989, Washington, D.C.
20. Interview with Michael Meltsner, 19 April 1989, Boston, Mass.; interview with James M. Quigley; "Summary of Discriminatory Practices at Hospitals Listed in March 3, 1965 Letter" and "Summary of Discriminatory Practices at Hospitals Listed in March 25, 1965 Letter," Hubert A. Eaton manuscripts, Wilmington, N.C.; "HEW Gets NAACP Complaints," *Modern Hospital*, July 1965, 105–122.
21. Interview with Sherry Arnstein, 31 January 1989, Washington, D.C.; "Compliance Reports of Northern and Southern Hospitals," Sherry Arnstein papers.
22. Ibid.
23. Anthony Celebrezze to Horace W. Busby, Jr, "Department of Health, Education, and Welfare Civil Rights Act of 1964 Progress Report," 1 July 1965, HU2 executive papers, Lyndon Baines Johnson Presidential Library.
24. Interview with Sherry Arnstein.
25. J. M. Quigley, "Hospitals and Civil Rights Act of 1964," *Journal of the National Medical Association* (1965): 455–459.
26. Ibid.
27. Interview with John Gardner, 22 March 1989, Washington, D.C.; interview with F. Peter Libassi, 4 December 1988, Hartford, Conn.; interview with James M. Quigley.
28. Interview with F. Peter Libassi.
29. F. Peter Libassi to Lee C. White and Douglass Cater, "Memorandum," 28 January 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
30. Interview with F. Peter Libassi; interview with Sherry Arnstein.
31. J. Spivak, "Medicare and Civil Rights: How Far Will HEW Go in Barring Hospital Discrimination?" *Wall Street Journal*, 2 February 1966, 1; A. L. Riday and W. J. Lear, *Health Care and the Negro Population* (New York: National Urban League, 1965); E. Langer, "Title VI: Universities, Others Affected by Federal Moves to End Discrimination by Aid Recipients," *Science*, 29 January 1965, 488–489; "1964 Rights Act Stirs Widespread Federal Activity," *Congressional Quarterly*, 9 April 1965, 617–623.
32. Interview with Philip Lee, 22 November 1988, Washington, D.C.; interview with Robert M. Ball, 21 February 1989, Washington, D.C.; interview with F. Peter Libassi; interview with John Gardner.
33. "Problems Remain as Government Launches 'Medicare,'" *Congressional Quarterly,* 1 July 1966, 1397; "HEW Launches Inspection Program in Stepped-Up Civil Rights Effort," *Congressional Quarterly*, 1 May 1966, 17; "Medicare Speeds Hospital Desegregation," *Medical World News*, 1 July 1966, 27.
34. American Hospital Association, *This Week for Hospitals*, 11 March 1966, Duke Endowment Archives, American Hospital Association file, January 1966–June 1966, Charlotte, N.C.; Surgeon General to Hospital Administrator, "Guidelines for Compliance with Title VI of the Civil Rights Act of 1964" and "Form 441," 2 March and 4 April 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
35. Irving J. Lewis to Douglass Cater, "Memorandum: Hospital Civil Rights Compliance and Medicare." 12 April 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
36. Interview with Charles Watts, 7 January 1989, Durham, N.C.
37. Interview with Lee Hyde, 8 February 1989, Asheville, N.C.; Clarence V. McKee, Jr, to Lyndon B. Johnson, "Personal Correspondence," 12 September 1966, ISI general file, Lyndon Baines Johnson Presidential Library.
38. F. Peter Libassi to Joseph Califano, Douglass Cater, and Nicholas Katzenbach, "Memorandum: Title VI Compliance—Schools and Hospitals," 1 June 1966; Libassi to Cater, "Memorandum: Hospital Compliance—Title VI," with attachment "Highlights of Public Information Activities in Connection with Hospital Compliance with Title VI of the Civil Rights Act," 18 June 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
39. Douglass Cater to the President, "Report on Hospital Civil Rights Compliance in the South," 18 June 1966, ISI executive file, Lyndon Baines Johnson Presidential Library; John Gardner, "Memorandum for the Vice President," 14 June 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
40. F. Peter Libassi to Douglass Cater, "Hospital Compliance—Title VI," 18 June 1966, ISI executive file, Lyndon Baines Johnson Presidential Library.
41. Ibid., 2.
42. Ibid., 4; F. Peter Libassi to Douglass Cater, "Hospital Compliance Program—Congressional Contacts," 28 June 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
43. Libassi to Cater. "Hospital Compliance—Title VI," 3.
44. John Gardner to Vice President Humphrey, "Memorandum," 14 June 1966, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
45. Philip R. Lee to Douglass Cater, "Memorandum: Presidential Meeting on Implementation of the Medicare Program," 1 June 1966, ISI executive file, Lyndon Baines Johnson Presidential Library.
46. Libassi to Cater, "Memorandum: Hospital Compliance—Title VI," with attachment.

47. Ibid.
48. Philip R. Lee to Douglass Cater, "Memorandum: Contingency Use of Federal Hospitals by Medicare Patients," 27 June 1966; Douglass Cater to the President, "Memorandum: Off-the-Record Meeting on Medicare—11:30 AM, Tuesday, June 28," Cater manuscripts, Lyndon Baines Johnson Presidential Library.
49. Douglass Cater to the President, "Short Statement for Television Tomorrow, June 29, 1966," Cater manuscripts, Lyndon Baines Johnson Presidential Library.
50. John Gardner to Lyndon Baines Johnson, "Memorandum for the President, July 6, 1966," ISI executive file, Lyndon Baines Johnson Presidential Library.
51. F. Peter Libassi to Joseph A. Califano, Douglass Cater, and Nicholas Katzenbach, "Title VI: Initiation of Deferral Action against Nineteen Hospitals Refusing to Comply," 20 September 1966, HU2 executive file, Lyndon Baines Johnson Presidential Library.
52. R.M. Nash, "Compliance of Hospitals and Health Agencies with Title VI of the Civil Rights Act," *American Journal of Public Health* 58 (1968): 246–251.
53. W. J. Cohen, "Brighter Horizons for Medical Care," *Journal of the National Medical Association* 58 (1966): 405–409.
54. F. Peter Libassi to Douglass Cater, "Memorandum: the Atlanta Hospitals," with attachment, "Report on Civil Rights Compliance Atlanta, Georgia Hospitals, August, 1966," prepared by Office of Equal Health Opportunity, Cater manuscripts, Lyndon Baines Johnson Presidential Library.
55. Derrick A. Bell to D. Robert Owen, "Notice of Hearing to One Hospital Refusing to Comply with Title VI of the Civil Rights Act of 1964, February 21, 1967," HU2 executive file, Lyndon Baines Johnson Presidential Library.
56. F. Peter Libassi to Douglass Cater, Joseph A. Califano, and John Doar, "Title VI Compliance: Final Decisions Against Six (6) Hospitals," with attachment, "Secretary's Report to Congress on Termination," 20 April 1967, HE5 executive file, Lyndon Baines Johnson Presidential Library.
57. F. Peter Libassi to Douglass Cater, Joseph A. Califano, and John Doar, "Title VI Compliance, Final Termination," with attachment, "Secretary's Approval and Notice to Congress, Schools and Hospitals," 25 May 1967, HU2 executive file, Lyndon Baines Johnson Presidential Library.
58. P. P. Reynolds, "Hospitals and Civil Rights, 1945–1963: *Simkins v. Moses H. Cone Memorial Hospital*," *Annals of Internal Medicine* 126 (1997): 898–906.
59. W. Cohen, "From Medicare to National Health Insurance," in *Toward New Human Rights*, ed., D. C. Warner (Austin, Tex.: University of Texas, 1977), 150.